

Analysis of Proposed Naturopathic Prescriptive Authority in Connecticut: Evidence-Based Public Health Assessment

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Subject: Scope of Practice Review—Naturopathic Physician Prescriptive Authority

Executive Summary

This report examines the Connecticut Naturopathic Physicians Association (CNPA) request for independent prescriptive, dispensing, and administration authority as submitted under the 2024–2025 scope of practice review process mandated by Section 61 of Public Act 24-68[1]. The analysis evaluates current naturopathic diagnostic and therapeutic practices in Connecticut against evidence-based medical standards, applies a risk stratification framework to common interventions, and assesses the likelihood that prescriptive authority would be exercised consistent with consensus clinical guidelines.

Key Findings:

- Current Connecticut naturopathic practice demonstrates systematic divergence from evidence-based diagnostic and therapeutic standards across multiple medical specialties.
- A risk stratification model applied to documented naturopathic interventions identifies 8 of 9 evaluated practices as high to severe risk based on evidence deficit, biological implausibility, patient harm potential, delay-of-care risk, and commercial conflict intensity.
- The proposed scope expansion would grant broad prescriptive authority without formulary limitations, oversight requirements, or restrictions on controlled substances typically imposed in other states[2].
- Available evidence suggests high probability that prescriptive authority would be integrated into the existing "parallel diagnostic and therapeutic ecosystem" rather than adhering to specialty society consensus guidelines.

Recommendation: The Department should require comprehensive evaluation of regulatory oversight mechanisms, collaborative practice requirements, and patient safety protections before considering expansion of naturopathic prescriptive authority.

Introduction

Regulatory Context

Licensed naturopathic physicians in Connecticut currently operate under Connecticut General Statutes Section 20-34, which permits diagnosis, laboratory testing, and various therapeutic modalities including mechanical therapies, nutrition counseling, and natural substance administration[3]. Current statute explicitly excludes prescription medication authority, requiring naturopathic physicians to refer patients to physicians, advanced practice registered nurses, or physician assistants for pharmaceutical prescribing.

The CNPA scope expansion request seeks to:

- 1. Independently prescribe pharmaceuticals without formulary restrictions
- 2. Independently dispense pharmaceuticals directly to patients
- 3. Independently administer pharmaceuticals, natural substances, and nutraceuticals via multiple routes (auricular, buccal, inhaled, intranasal, intramuscular, intravenous, and others)
- 4. Achieve statutory recognition as "primary care-type providers"
- 5. Remove restrictions on co-location of diagnostic, laboratory, and prescribing services in single-provider settings[1]

Legislative Status

The scope expansion appears in multiple legislative vehicles:

Bill Number	Description	Scope
SB 177 (2024)	Authorizing Naturopathic Physicians To Prescribe Medication	General prescriptive authority
SB 1069 (2025)	Permitting Naturopathic Physicians To Prescribe Medication	General prescriptive authority

SB 1325 (2025)	Permitting Naturopathic Physicians To Prescribe and Administer Vitamin B12	Limited (Vitamin B12 only)
SB 246 (2025)	Study of Viability for Naturopathic Physicians as Primary Care Providers	Primary care provider designation study

Table 1: Connecticut legislative proposals related to naturopathic scope expansion, 2024-2025

Methodology

This analysis examines:

- Documented diagnostic and therapeutic practices advertised by Connecticut-licensed naturopathic physicians
- Evidence-based medical consensus guidelines from specialty medical societies
- Risk assessment across five domains: evidence deficit, biological implausibility, patient harm potential, delay-of-care risk, and commercial conflict intensity
- Comparative state regulatory frameworks
- Predictions regarding likely prescriptive patterns if authority is granted

Current Practice Patterns: Diagnostic Methods

Non-Validated Laboratory Testing

Analysis of Connecticut naturopathic clinical materials reveals systematic reliance on laboratory panels that diverge from consensus guidelines issued by relevant medical specialty societies[4]. The following table summarizes common diagnostic practices and their evidence status:

Diagnostic Practice	Description	Scientific Evidence Status
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IgG food sensitivity testing	Blood tests measuring IgG antibodies to foods used to identify sensitivities causing chronic symptoms	Lacks clinical utility; AAAAI and ACAAI state IgG levels reflect exposure, not allergy or intolerance; no causal link to symptoms proven in controlled trials[5]
Organic acid testing (OAT)	Urine analysis for metabolic byproducts to assess gut dysbiosis, neurotransmitter issues, or detoxification capacity	Not validated for clinical diagnosis; American Academy of Pediatrics rejects for routine use due to poor specificity/sensitivity and overlap with normal variation[6]
Chronic Lyme disease testing	Non-standard panels beyond CDC two-tier serology for persistent post-treatment infection	IDSA guidelines refute; most positive results represent false positives or past resolved infection; no reliable test for chronic Lyme[7]
Adrenal fatigue assessment	Salivary cortisol patterns or DHEA levels to diagnose subclinical adrenal insufficiency	Endocrine Society declares adrenal fatigue unproven; cortisol tests unreliable outside clinical deficiency states; symptoms nonspecific[8]
Methylation panels (MTHFR polymorphisms)	Genetic or functional tests for methylation defects linked to fatigue, mood disorders	ACMG: MTHFR variants common (up to 40% of population), not causal for most symptoms; treatment lacks evidence[9]
Urine neurotransmitter testing	Quantification of dopamine, serotonin, etc., in urine to guide supplementation	Psychiatry/neurology consensus: urine levels do not reflect brain function; poor correlation with CNS activity; no validated therapeutic application[10]

Table 2: Non-validated diagnostic practices and evidence-based medical consensus

Pattern of Diagnostic Expansion

These diagnostic practices share common characteristics:

- **Target conditions with clinical ambiguity:** Chronic Lyme disease, adrenal fatigue, food sensitivities, and methylation defects represent diagnostic categories not recognized by relevant specialty societies or involve extrapolation beyond validated indications.
- **Generate commercial testing revenue:** Specialty laboratory panels typically require out-of-pocket payment and create ongoing monitoring relationships.
- **Justify subsequent interventions:** Positive or abnormal results establish rationale for supplement regimens, IV therapies, and other revenue-generating services.
- **Lack external validation:** Testing protocols do not adhere to consensus guidelines from infectious disease (IDSA), allergy/immunology (AAAAI, ACAAI), endocrinology (Endocrine Society), genetics (ACMG), or psychiatry specialty organizations.

Current Practice Patterns: Therapeutic Modalities

Non-Evidence-Based and Extrapolated Therapies

Connecticut naturopathic practices promote therapeutic interventions that deviate from FDA-approved indications, lack rigorous clinical trial support, or contradict established biological principles:

Therapeutic Practice	Description	Scientific Evidence Status
Homeopathy	Ultra-dilute remedies claimed to stimulate healing via "like cures like" principle	Biologically implausible; meta-analyses (Lancet 2005, NHMRC 2015) show effects indistinguishable from placebo; contradicts pharmacology principles[11][12]

Low-dose immunotherapy (LDI/LDA)	Subcutaneous microdoses of allergens/antigens for allergies, autoimmunity, chronic illness	No rigorous RCTs support efficacy; AAAAI warns of risks without benefits; deviates from standard immunotherapy dosing validated for IgE-mediated allergy[13]
Supportive Oligonucleotide Therapy (SOT) for Lyme	Peptide or nucleic acid sequences targeting supposed persistent Lyme pathogens	Lacks FDA approval or clinical trial data; IDSA rejects as unproven for chronic Lyme; potential for immune overstimulation without proven pathogen clearance[14]
IV nutrient infusions (non-deficiency states)	High-dose vitamins/minerals IV for fatigue, infections, detoxification	No evidence for routine use beyond deficiency; risks include vein damage, infection; American College of Physicians: unsupported for chronic conditions[15]
Hyperbaric oxygen therapy (HBOT) for chronic Lyme/fatigue	Off-label HBOT for persistent symptoms, not wound healing	FDA restricts HBOT to 13 indications; Undersea and Hyperbaric Medical Society: no data for Lyme or fatigue; risks include barotrauma, oxygen toxicity[16]
Craniosacral therapy	Gentle skull/sacral manipulation for pain, neurological issues	No measurable cranial bone motion exists; systematic reviews (Cochrane) find no benefit beyond placebo for any condition[17]
Detoxification protocols	Colonics, chelation, saunas for toxin removal in chronic illness	No evidence toxins accumulate as claimed; NIH and gastroenterology societies: unnecessary/risky for healthy individuals; may disrupt microbiome[18]

Table 3: Non-validated therapeutic practices and evidence-based medical consensus

Pattern of Therapeutic Boundary Stretching

Analysis reveals systematic extrapolation of legitimate medical technologies beyond validated indications:

- **Legitimate technology, non-validated application:** IV infusions, hyperbaric oxygen therapy, and laboratory testing represent established medical tools used outside FDA-approved or evidence-supported indications.
- **Biologically implausible modalities:** Homeopathy and craniosacral therapy lack mechanistic plausibility under established principles of pharmacology and anatomy.
- **Commercial bundling:** Therapies are frequently packaged with diagnostic testing and supplement sales in integrated service models.
- **Chronic, ambiguous conditions:** Interventions target conditions characterized by subjective symptoms, unclear etiology, and limited objective outcome measures (chronic Lyme, chronic fatigue, fibromyalgia, food sensitivities).

Risk Stratification Analysis

Methodology

A five-domain risk assessment was applied to documented naturopathic interventions. Each domain receives a score of 0-3 (higher = greater concern):

- **Evidence Deficit:** Degree to which intervention lacks support from rigorous clinical trials or contradicts systematic reviews
- **Biological Implausibility:** Extent to which proposed mechanism violates established principles of pharmacology, physiology, or biochemistry
- **Patient Harm Risk:** Direct potential for adverse events, complications, or iatrogenic injury
- **Delay-of-Care Risk:** Likelihood that intervention postpones evidence-based diagnosis or treatment
- **Commercial Conflict Intensity:** Degree to which financial incentives may influence clinical decision-making

Aggregate scores categorize risk levels:

- 0-4: Low
- 5-8: Moderate
- 9-12: High
- 13-15: Severe Regulatory Concern

Results

Intervention	Evid. Def.	Impl.	Harm	Delay	Comm .	Total	Risk Level
Homeopathy	3	3	1	3	2	12	High
SOT for Lyme	3	2	2	3	3	13	Severe
IgG Food Panels	3	1	2	2	3	11	High
Adrenal Fatigue Testing	3	2	1	2	3	11	High
IV Vitamin Therapy (non-deficiency)	2	1	2	2	3	10	High
HBOT (chronic Lyme)	2	1	2	2	3	10	High
Craniosacral Therapy	3	2	1	2	2	10	High
Organic Acid Testing	3	1	1	2	3	10	High

Acupuncture (systemic disease claims)	2	1	1	2	2	8	Moderate
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Table 4: Risk stratification of common naturopathic interventions (0–3 scale per domain)

Interpretation

Eight of nine evaluated interventions score in the High (9–12) or Severe (13–15) risk categories. This reflects:

- Substantial evidence deficits across most modalities
- Significant delay-of-care risk when interventions substitute for evidence-based diagnosis and treatment
- High commercial conflict intensity due to direct financial benefit to practitioners from laboratory testing, dispensing, and procedure fees
- Moderate to high biological implausibility for several core modalities (homeopathy, craniosacral therapy, SOT)

Notably, these interventions occur in the absence of statutory requirements for physician oversight, collaborative practice agreements, or consultation mandates for serious medical conditions.

Predicted Impact of Prescriptive Authority

Likelihood of Non-Standard Prescribing

Available evidence suggests high probability that prescriptive authority would be exercised in patterns consistent with current diagnostic and therapeutic practices—that is, characterized by extension beyond evidence-based guidelines. This assessment is based on:

1. Established Pattern of Non-Standard Practice

Current Connecticut naturopathic practice demonstrates stable reliance on:

- Non-validated diagnostic tools (IgG panels, non-standard Lyme testing, adrenal fatigue assessment, urine neurotransmitter testing, methylation panels) that depart from consensus guidelines in allergy/immunology, infectious disease, endocrinology, and psychiatry

- Therapeutic modalities (IV infusions, HBOT) stretched beyond evidence-supported indications, particularly for chronic Lyme, fatigue, and medically ambiguous conditions

This pattern indicates a practice culture favoring extension of clinical tools beyond standard-of-care boundaries rather than adherence to specialty society consensus guidelines.

2. Parallel Care Ecosystem

Current practice operates as a "parallel diagnostic and therapeutic ecosystem" adjacent to mainstream standards of care, characterized by:

- Widened diagnostic categories (chronic Lyme, adrenal fatigue) not recognized by relevant specialty organizations
- Repeated monitoring and testing to reinforce disease identity
- Commercial bundling of laboratory panels, supplements, and adjunctive procedures (IV therapy, HBOT, saunas) marketed as comprehensive care
- Blurred boundaries between experimental and established therapeutic categories

Adding prescriptive authority to this ecosystem would likely result in assimilation into existing practice patterns rather than transformation toward conventional clinical restraint.

3. Structural Integration of Prescribing into Commercial Model

The CNPA scope expansion explicitly frames prescriptive authority within a "comprehensive care in one location" model, specifically combining:

- Diagnosis (including non-validated testing)
- Laboratory ordering (specialty panels)
- Prescribing and dispensing (requested authority)
- Administration (IV, IM, inhaled, intranasal routes)

This structural design embeds prescribing within the same business and conceptual framework that currently drives non-validated diagnostics and boundary-stretched therapeutics, making similar extension of pharmaceutical use predictable.

4. External Expert Assessment

The American Medical Association's impact statement on the CNPA scope review warns that "granting broad prescriptive authority to naturopaths—without the usual limitations on controlled substances that most states impose—poses a serious threat to patient safety, precisely because of misinformed or non-evidence-based prescribing"[19].

Independent medical and policy observers infer high probability that pharmaceutical use would mirror current stretching patterns observed with non-drug modalities.

5. Concrete Extrapolation Examples

Current Connecticut naturopathic marketing for chronic Lyme and complex chronic illness features aggressive use of HBOT, IV nutrient infusions, and adjunct therapies with causal claims exceeding current evidence. Prescriptive authority would predictably add:

- **Antibiotics:** Prolonged or combination antibiotic regimens for "chronic Lyme" beyond IDSA guidelines
- **Psychotropics:** Neurotransmitter-balancing medications based on non-validated urine testing
- **Hormones:** Thyroid and adrenal hormone manipulation for "adrenal fatigue" and subclinical hypothyroidism
- **Off-label medications:** Pharmaceutical integration into existing detoxification, IV therapy, and HBOT protocols for medically ambiguous conditions

The same clinical logic driving current IV vitamin and HBOT use for chronic Lyme would almost certainly favor expanded pharmaceutical interventions in ways that deviate from infectious disease, psychiatry, and endocrinology consensus guidelines.

Overall Assessment

Considering base-rate behavior (current diagnostics and therapeutics), the structure of requested scope expansion (one-stop diagnosis/labs/prescribing/administration), and independent policy assessments, the likelihood that naturopathic physicians would use prescriptive powers in an extended or stretched manner is high. A conservative characterization: deviation from standard of care in prescribing would represent expected behavior, not edge-case occurrence, given the existing documented pattern.

Comparative State Regulatory Frameworks

National Landscape

As of 2025, 23 states plus the District of Columbia, Puerto Rico, and the US Virgin Islands have naturopathic licensure or registration laws[20]. Among licensed states:

- 15 states grant some form of prescriptive authority[2]
- Most states restrict controlled substance prescribing or exclude it entirely

- Eight states (Arizona, California, New Hampshire, New Mexico, Oregon, Utah, Vermont, Washington) allow limited controlled substance prescribing[2]
- Three states (Colorado, Maryland, Rhode Island) require collaborative practice agreements with licensed physicians[2]

Connecticut as Regulatory Outlier

The CNPA proposal requests:

- Broad prescriptive authority without formulary restrictions
- Independent dispensing authority
- Multi-route administration authority (including IV)
- No collaborative practice requirements
- No physician oversight mandates
- No controlled substance restrictions explicitly mentioned in scope request[1]

This scope would position Connecticut as an outlier relative to other states with naturopathic prescriptive authority, most of which impose formulary limitations, controlled substance restrictions, or collaborative practice requirements.

Regulatory Oversight Considerations

Current Statutory Framework

Connecticut General Statutes Section 20-34 defines naturopathic practice as encompassing diagnosis, laboratory testing, and various therapeutic modalities. Notably, current statute does not:

- Require adherence to evidence-based medical standards
- Mandate physician consultation for serious medical conditions
- Establish collaborative practice requirements
- Define prohibited diagnostic or therapeutic practices
- Require reporting of adverse events

Current regulatory framework characterizes naturopathic practice as the "science, art, and practice" of naturopathy, effectively establishing professional self-definition of scope rather than external evidence-based standards[21].

Regulatory Gaps

Documented practice patterns reveal systematic divergence from evidence-based standards across multiple medical specialties without apparent regulatory intervention. This suggests:

- **Enforcement gap:** Existing oversight mechanisms do not effectively address non-validated diagnostic testing or therapeutically implausible modalities
- **Standards gap:** Absence of statutory requirement for adherence to consensus clinical guidelines
- **Accountability gap:** No mandate for physician co-management of serious conditions or high-risk interventions
- **Transparency gap:** Limited public reporting of adverse events, scope violations, or disciplinary actions

Implications for Prescriptive Authority

Granting independent prescriptive authority without addressing existing regulatory gaps would:

- Extend pharmaceutical access to a practice ecosystem demonstrating systematic non-adherence to evidence-based standards
- Create potential for pharmaceutical integration into non-validated diagnostic and therapeutic protocols
- Lack safeguards present in most state naturopathic prescribing frameworks (formulary restrictions, collaborative practice requirements, controlled substance limitations)
- Potentially delay evidence-based diagnosis and treatment for serious medical conditions

Public Health Considerations

Patient Safety Concerns

The risk stratification analysis identifies multiple interventions with high potential for:

- **Direct harm:** IV therapy complications (infection, vein damage), HBOT risks (barotrauma, oxygen toxicity), chelation therapy adverse events
- **Diagnostic delay:** Non-validated testing for serious conditions (chronic Lyme, endocrine disorders, psychiatric conditions) may postpone appropriate workup
- **Treatment delay:** Time spent on non-evidence-based interventions delays proven therapies for treatable conditions
- **Financial exploitation:** High out-of-pocket costs for non-validated testing and therapies with dubious benefit

Adding prescriptive authority amplifies these risks by:

- Enabling pharmaceutical treatment of conditions diagnosed via non-validated methods

- Potentially prolonging ineffective treatment before referral to evidence-based care
- Introducing additional adverse event risk from medications prescribed outside consensus guidelines

Consumer Protection Issues

Current practice patterns raise concerns regarding:

- **Informed consent:** Patients may not be adequately informed that diagnostic tests and therapies diverge from medical consensus guidelines
- **Transparency:** Marketing materials may not disclose evidence status of interventions or FDA approval status
- **Financial conflicts:** Direct financial benefit from laboratory testing, supplement dispensing, and procedure fees may influence clinical recommendations
- **Scope confusion:** Patients may not understand differences between naturopathic physicians and medical doctors/osteopathic physicians

Connecticut consumer protection statutes (CUTPA) and patient rights frameworks may not adequately address these issues within current naturopathic regulatory structure[21].

Recommendations

Based on documented practice patterns, risk stratification analysis, and regulatory framework assessment, the following recommendations are offered:

Immediate Action Items

1. **Delay prescriptive authority expansion** until comprehensive regulatory safeguards are established
2. **Commission independent review** of current naturopathic diagnostic and therapeutic practices relative to evidence-based medical standards
3. **Establish reporting requirements** for adverse events associated with naturopathic interventions
4. **Require disclosure** to patients when diagnostic tests or therapies diverge from medical specialty society consensus guidelines

Regulatory Framework Reforms

Should prescriptive authority be considered, the following safeguards should be mandatory:

1. **Formulary restrictions:** Define permitted medication classes based on demonstrated competency and safety considerations
2. **Controlled substance exclusions:** Prohibit prescribing of Schedule II-IV controlled substances

3. **Collaborative practice requirements:** Mandate written collaborative agreements with licensed physicians for patients with serious medical conditions
4. **Consultation triggers:** Require physician referral for specific conditions (cancer, serious infections, cardiovascular disease, psychiatric emergencies)
5. **Evidence-based standards:** Establish statutory requirement for adherence to consensus clinical practice guidelines from relevant medical specialty societies
6. **Continuing education:** Require documented training in pharmacology, evidence-based medicine, and clinical guideline application
7. **Oversight mechanisms:** Implement regular practice audits, prescribing pattern reviews, and adverse event monitoring

Consumer Protection Measures

1. **Mandatory disclosure statements** when diagnostic tests or therapies lack validation by relevant medical specialty organizations
2. **Financial conflict disclosure** when practitioners have direct financial interest in recommended laboratories, supplements, or procedures
3. **Scope of practice clarification** in patient-facing materials explaining differences between naturopathic physicians and medical doctors/osteopathic physicians
4. **Insurance coverage restrictions** for non-validated diagnostic tests and therapeutically implausible interventions

Conclusion

Analysis of documented Connecticut naturopathic practice patterns reveals systematic divergence from evidence-based medical standards across diagnostic and therapeutic domains. Risk stratification identifies the majority of common naturopathic interventions as high to severe risk based on evidence deficit, biological implausibility, patient harm potential, delay-of-care risk, and commercial conflict intensity.

The requested scope expansion would grant broad prescriptive authority without the formulary restrictions, collaborative practice requirements, or controlled substance limitations typical of other state naturopathic prescribing frameworks. Given documented practice patterns, there is high probability that prescriptive authority would be integrated into the existing "parallel diagnostic and therapeutic ecosystem" characterized by non-validated diagnostics and therapeutically stretched interventions.

Current regulatory framework lacks safeguards to ensure evidence-based prescribing, patient safety protections, and accountability mechanisms. Granting prescriptive authority under current conditions presents substantial public health risk.

The Department should require establishment of comprehensive regulatory safeguards—including formulary restrictions, collaborative practice requirements, evidence-based standards mandates, and enhanced oversight mechanisms—before considering expansion of naturopathic prescriptive authority.

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